STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151528	A. BUILDING _____ B. WING _____	C 11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISITING NURSE SERVICE HOSPICE OF CENTRAL INDIANA	**4701 N KEYSTONE AVE INDIANAPOLIS, IN 46205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS This visit is for a federal and state hospice complaint investigation. Complaint #IN000119423 - Unsubstantiated: Lack of sufficient evidence Survey Date: 11/16/12 Facility # 007846 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Medicaid # 200141480A Visiting Nurse Services of Central Indiana, Inc. is in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.100(b) Governing Body and Administrator as related to this complaint. Quaality Review: Joyce Elder, MSN, BSN, RN November 20, 2012	L 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.